Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: VISTA MEDICAL CENTER 4301 VISTA RD PASADENA TX 77504-2117	MFDR Tracking #: M4-07-7144-01 DWC Claim #: Injured Employee:
Respondent Name and Carrier's Austin Representative Box #: TEXAS MUTUAL INSURANCE COMPANY Box #: 54	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Vista Medical Center Hospital charges fair and reasonable rates for its services. Specifically, these rates are based upon a comparison of charges to other carriers and the amount of reimbursement received for these same or similar services. The amount of reimbursement deemed to be fair and reasonable by Vista Medical Center Hospital is at a minimum, 70% of the billed charges. This is supported by the Focus managed care contract."

Amount in Dispute: $12,290.46

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Ingenix recommended to the Commission that a market reimbursement of 140% of Medicare's Hospital Outpatient Prospective Payment System would meet the statutory requirements of Section 413.011(d)… The requestor listed code 62350 on its bill… To meet the Ingenix recommended MAR, Texas Mutual will issue a supplemental payment of $2,035.89… The requestor, on the other hand, has failed to submit any information to support its billing of $19,590.65 is either fair or reasonable for the service provided."

Response Submitted by: Texas Mutual Insurance Company, 6210 E. Hwy 290, Austin, Texas 78723

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
1/30/2007	W10, 713, 894	Inpatient Surgery	$12,290.46	$0.00
			Total Due:	$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code §413.011(a-d), titled *Reimbursement Policies and Guidelines*, and former Division rule at 28 TAC §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997 set out the reimbursement guidelines.

This request for medical fee dispute resolution was received by the Division on July 6, 2007.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason code:
   - W10 – NO MAXIMUM ALLOWABLE DEFINED BY FEE GUIDELINE. REIMBURSEMENT MADE BASED ON INSURANCE CARRIER FAIR AND REASONABLE REIMBURSEMENT METHODOLOGY.
   - 713 – FAIR AND REASONABLE REIMBURSEMENT FOR THE ENTIRE BILL IS MADE ON THE 'O/R SERVICE' LINE ITEM.
   - 894 - FAIR AND REASONABLE REIMBURSEMENT FOR THE ENTIRE BILL IS MADE ON THE 'O/R SERVICE' LINE ITEM.
2. The Division's former rule at 28 TAC §134.401(b)(1)(B), effective August 1, 1997, 22 TexReg 6264, defines inpatient services as "Health care, as defined by the Texas Labor Code, §401.011(19), provided by an acute care hospital and rendered to a person who is admitted to an acute care hospital and whose length of stay exceeds 23 hours in any unit of the acute care hospital." Review of the anesthesia record finds that anesthesia was first administered to the injured

worker at 8:40 AM on 1/30/2007. Review the medical records finds that the injured worker was discharged on 1/31/2007 at 9:17 AM. The submitted documentation supports that the length of stay exceeded 23 hours; the Division therefore concludes that the services in dispute are inpatient services.

3. This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of former Division rule at 28 TAC §134.401, effective August 1, 1997, 22 TexReg 6264. Review of the submitted documentation finds that the length of stay was one calendar day. The type of admission is surgical; therefore, the standard surgical per diem amount of $1,118.00 multiplied by the length of stay of 1 day yields a reimbursement amount of $1,118.00. This amount less the amount paid by the insurance carrier of $19,590.65 leaves an amount due of $0.00 for the surgical admission.
4. Additionally, review of the submitted records finds that the health care provider billed for pharmaceuticals exceeding $250.00 per dose. Per former Division rule at 28 TAC §134.401(c)(4)(C) "Pharmaceuticals administered during the admission and greater than $250 charged per dose shall be reimbursed at cost to the hospital plus 10%." However, review of the submitted documentation finds no documentation of the cost to the hospital of the disputed pharmaceuticals. Therefore, no additional reimbursement can be recommended.
5. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code §401.0111, §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code §133.307, §134.1, §134.401
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

	Grayson Richardson	**7/29/2011**
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.